92-1931

No.

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

BERTHA GARELICK, *et al.*,

Petitioners,

vs.

DONNA E. SHALALA, Secretary of the U.S. Department of Health and Human Services, and WILLIAM TOBY, Administrator, Health Care Financing Administration,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether federal caps on physician fees chargeable to Medicare patients, designed solely to alleviate a social ill for which physicians are not responsible, constitute a taking without just compensation when applied to physicians who are compelled to treat Medicare patients.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Bertha Garelick, *et al.*, respectfully request that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit.[1]

OPINIONS BELOW

The opinion of the court of appeals is reported at 987 F.2d 913 (2d Cir. 1993) and reprinted in the Appendix ("Pet. App.") at A-1. The opinions of the district court are reported at

[1] The other petitioners are Yolanda Restaino, Elena Savino, David Atkinson, Bruce Konrad and Peter T. Pickering.

784 F.Supp. 108 (S.D.N.Y.) and 1992 WL 71946 (Mar. 24, 1992, S.D.N.Y.) and reprinted at Pet. App. B-1, C-1. A subsequent opinion of the district court is unreported and reprinted at Pet. App. D-1.

JURISDICTION

The judgment of the court of appeals was entered on March 5, 1993. This Court's jurisdiction is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

The section of the Medicare statute at issue in this case, 42 U.S.C. Section 1395w-4(g), provides:

> (g) LIMITATION ON BENEFICIARY LIABILITY -
>
> (1) LIMITATION ON ACTUAL CHARGE FOR UNASSIGNED CLAIMS. – If a nonparticipating physician knowingly and willfully bills on a repeated basis for physicians' services (furnished after January 1, 1991) an actual charge in excess of the limiting charge [fee cap] described in paragraph (2) and for which payment is not made on an assignment-related basis under this part, the Secretary may apply sanctions against such physician in accordance with section 1842(j)(2).

STATEMENT OF THE CASE

This petition challenges a Second Circuit decision holding that statutory price controls over the amount private anesthesiologists may charge well-to-do Medicare beneficiaries, apart from what Medicare itself pays, is not a taking of property requiring compensation under the Fifth Amendment.

The principal issue raised by this petition is whether a taking, in the form of statutory price regulation, unfairly segregates anesthesiologists, and requires them to underwrite Congress' program calculated to relieve the national burden of elderly patients who do not have the means to afford to pay medical bills.

This petition is complicated by a psychological factor which should be addressed candidly at the outset: the object of this case appears to be higher fees for doctors. That obviously would not be a popular position to advocate to anyone, let alone a Court whose members or families may themselves be covered by Medicare. But higher fees are *not* the principal objective of this petition. It has twin goals: professional independence for physicians and legislative responsibility for Congress.[2]

Statutory Background

In 1984, Congress introduced the idea of price controls which limited the total amount physicians may charge Medicare Part B beneficiaries on unassigned claims. Section 2306 of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494 ("DEFRA"), *codified at* 42 U.S.C. § 1395u(h), required physicians to decide annually whether they would be "participating" or "non-participating" physicians. *Id. See also Whitney v. Heckler*, 780 F.2d 963, 966 (11th Cir.), *cert. denied, sub nom. Whitney v. Bowen*, 479 U.S. 813 (1986). For those who elected non-participation, DEFRA imposed a temporary fee freeze which prohibited such physicians from charging Medicare patients in excess of a physician's actual charges for the calendar quarter beginning April 1, 1984. 42 U.S.C. § 1395u(j). Physicians who willfully violated this restriction were subject to penalties.

This price freeze was not restricted to the amount that Medicare pays, but dictated the permissible fees the non-participating private physician could charge to Medicare beneficiaries above the Medicare amount, irrespective of the beneficiary's ability to pay.

In 1986, the government extended its web of regulation by enacting the Omnibus Budget Reconciliation Act of 1986, Pub. L.

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[2] This case is the direct outgrowth of Congressional shortsightedness in not enacting income-based mandatory assignment for Medicare beneficiaries to protect those older citizens who genuinely are the objects of legitimate Congressional concern. Jurisdiction in the court below was based on 28 U.S.C. § 1331.

No. 99-509, 100 Stat. 1874, which effectively replaced the DEFRA temporary freeze with a new fee cap, known as physicians' Maximum Allowable Actual Charge, or MAAC. 42 U.S.C. § 1395u(j)(1)(B)(i). The MAAC held permissible physician fees to the level which existed during the second quarter of 1984. Those fees remained in effect at that level through 1990.

In 1989, Congress went further in putting limits on what private physicians could charge Medicare enrollees — the legislators enacted yet another fee cap keyed to the Medicare allowed fee, setting it at a percentage above the Medicare fee (initially 125%). The new cap was contained in the Omnibus Budget Reconciliation Act of 1989. *See* P.L. 101-239, Sec. 6102(a), 42 U.S.C. § 1395w-4(g). This is the fee cap at issue in this petition.

Medicare and Anesthesiology

When Medicare Part B was first enacted the idea was simplicity itself: the Government would set up a trust fund to pay 80% of doctors' charges for treating Medicare patients, and the patients would pay the remaining 20% as coinsurance. But Congress did not foresee how expensive the program would become as the number of beneficiaries increased and high-tech and costly medical services became available. Government administrators then started to develop strategies to contain program costs. One of these strategies was to reduce beneficiary reimbursements. This caused the patients' share of doctors' bills to move from 20% up to 30% . . . to 40% . . . to 50% . . . in some cases to 60% and beyond. The patients' share of the charges stopped being called "coinsurance" and became known as "balance billing."

Although a growing number of doctors have signed up as "participating physicians" and agreed to accept Medicare's approved charges as full payment for their services, these physicians are primarily family doctors and specialists working in their own offices. Highly-skilled surgical team specialists are generally not participating physicians. Their customary charges are usually much higher than the amount allowed by Medicare, and they look to the patient to pay their full fee directly, and the patients then seek reimbursement from Medicare and their private insurance policies.

As Part B reimbursement amounts have dropped well below physicians' charges, laypersons understandably are tempted to criticize the high fees of surgical support specialists like anesthesiologists. But there is an incontestable public interest in allowing these charges for those who can afford to pay them. High incomes have become increasingly necessary to compete for the best and brightest graduates of medical schools. Such graduates carry the most advanced skills directly to the high-paying specialties where these skills are most needed. One result of high fees and high incomes has been the extraordinary advances in medical science which have taken place in the past few years — open-heart surgery, angioplasty, pacemakers, lens implants, organ transplants, total hip and knee replacements, brain surgery, and a whole range of cancer surgery. Many more new developments are in the offing.

These advances have been particularly significant in the field of anesthesiology, where advanced physician skills have permitted patients to undergo and survive surgical procedures which previously would never have been possible. It is the anesthesiologist who keeps the patient breathing during lung surgery, the patient's blood flowing during an open-heart operation, and who, in every major surgery, is responsible for the patient's welfare. He (or she) is the patient's surrogate and advocate, tells the surgeon when problems loom, and takes the necessary corrective steps to bring them under control.

As the spread between Medicare allowances and physician charges grew wider and wider, Congress attempted to deal with the rift as part of the total problem of "cost containment." In 1989, Congress adopted comprehensive legislation revising the Medicare reimbursement system. As a subsidiary part of the larger legislative package, Congress also passed Section 1395w-4(g), the subject of this litigation. That section specifically addressed the question of "balance billing" — the amount a physician could charge to a Medicare patient above the Medicare approved charge. The idea was to return to something approaching the original notion that Medicare would pay 80% of the doctor's charge and that the patient would pay 20%,

although Congress did not quite go that far. Instead, it compromised and limited the doctor's charge to Medicare patients to 125% of the Medicare approved charge.[3] The concept behind the legislation was to provide protection for lower income Medicare patients, without secondary coverage to fill the gaps, against high balance-billing by non-participating physicians. The remedy for physicians who do not agree with the fee cap limitation is to decline to treat Medicare patients (which will eventually affect the quality of patient care if many doctors refuse to treat Medicare patients in high skills fields).

Refusing to treat Medicare patients, however, is *not* an available option for anesthesiologists, especially those based in hospitals, which is the keystone of the constitutional attack on the statute in this petition as an unlawful taking of property without just compensation.

Anesthesiologists usually work full-time in the hospital where the surgery takes place. They are "locked in" to treating Medicare patients and therefore the new fee cap legislation is *mandatory* for them — unlike most other medical specialties.

The fee cap directly affects the anesthesiologist, roughly half of whose fee is automatically taken away for every Medicare patient he or she is obliged to treat. This is not a case of implementing a statute to protect lower-income Medicare patients, it protects *all* Medicare patients, including the well-to-do (who could afford to pay the doctor's customary fee or purchase private health insurance to fill the gap) because the Congress made no distinction between rich and poor in the legislation.

REASON WHY WRIT SHOULD BE GRANTED

The district court dismissed the complaint and then granted reconsideration, but affirmed its earlier grant of summary judgment for defendants. The court of appeals affirmed on the

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[3] The 125% cap in 1991 shrinks to 120% in 1992, and to 115% thereafter. 42 U.S.C. § 1395w-4(g)(2).

ground that there was no taking of property from petitioner anesthesiologists requiring compensation under the Fifth Amendment. The Second Circuit recognized as "appealing" petitioners' position that "[b]ecause they are not the source of the social ill that Congress allegedly sought to address through the limiting charge provisions, . . . the statutory scheme gives rise to a taking under the logic of the *Pennell [v. San Jose*, 485 U.S. 1 (1988)] dissent," Pet. App. A-11, but it declined to follow this takings theory "[u]ntil Justice Scalia's view is adopted by a majority of the Court. . . ." *Id.*

The Second Circuit's opinion is fundamentally at odds with recent trends in this Court's analysis of the takings clause and implicates issues of physician independence which are of paramount significance to America's health care system. For these compelling reasons, the writ should be granted in this case.

ARGUMENT

THE FEE CAPS IN THIS CASE HAVE IMPERMISSIBLY FORCED PETITIONER ANESTHESIOLOGISTS TO BEAR SOCIAL BURDENS WHICH THE TAKINGS CLAUSE MANDATES SHOULD BE BORNE BY THE PUBLIC AS A WHOLE

The takings clause of the Fifth Amendment to the United States Constitution provides that "private property [shall not] be taken for public use without just compensation." U.S. Const. Amend. V. This Court has "repeatedly observed that the purpose of [the takings clause] is to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole." *Pennell v. San Jose*, *supra*, at 19-20 (1988), *quoting Armstrong v. United States*, 364 U.S. 40, 49 (1960); *see also First English Evangelical Lutheran Church of Glendale v. County of Los Angeles*, 482 U.S. 304, 318-19 (1987); *Webb's Fabulous Pharmacies, Inc. v. Beckwith*, 449 U.S. 155, 163 (1980); *Agins v. City of Tiburon*, 447 U.S. 255, 260 (1980); *Penn Central Transportation Co. v. City of New York*, 438 U.S. 104, 123 (1978).

The clause therefore stands as a mandate of our fundamental law that the burdens of maintaining civil society be allocated with an even hand. The fee caps at issue here constitute a direct violation of this constitutional principle, since their sole function is to single out physicians and compel them to subsidize a Congressional program aimed at alleviating the national problem of elderly patients who do not have the means to afford to pay medical bills.

Indeed, the Second Circuit itself acknowledged that the OBRA-89 fee caps were intended by Congress as a protection for Medicare patients against "balance billing." *See* Pet. App. at A-5, *quoting*, H.R. Rep.No. 247, 101st Cong., 1st Sess. 348, *reprinted in* 1989 U.S.C.C.A.N. 1906, 2074. The caps are therefore in truth a social welfare program accomplished through mandatory price controls rather than the taxing power.

The analysis of Justice Scalia, in his separate opinion joined by Justice O'Connor, in the case of *Pennell v. San Jose*, *supra*, 485 U.S. at 15 (Scalia, J. concurring in part and dissenting in part) shows why such a price regulation is unsound and unconstitutional.[4]

Pennell involved a facial challenge to a "tenant hardship" provision of a rent control ordinance, alleged to run afoul of the

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[4] The district court found that Justice Scalia's analysis of the takings issue has "considerable logical force and may foreshadow a future shift in Supreme Court jurisprudence. . . ." Pet. App. at B-12 n.5 The court, however, failed to appreciate that Justice Scalia's concurrence is not a departure from, but essentially a synthesis and distillation of, the relevant case law on the takings clause. Both courts below erred in finding that concurrence at odds with settled Supreme Court doctrine that has "consistently affirmed that States have broad power to regulate housing conditions in general and the landlord-tenant relationship in particular without paying compensation for all economic injuries that such regulation entails." *Id.*, *quoting Loretto v. Teleprompter Manhattan CATV Corp.*, 458 U.S. 419, 440 (1982) (citing *Bowles v. Willingham*, 321 U.S. 503, 517-18 (1944)). The court of appeals also failed to see that in *Pennell*, Justices Scalia and O'Connor were *not* advocating "compensation for *all* economic injury" entailed by regulation, but simply pointing out the long-recognized unconstitutionality of forcing individuals to bear those burdens which should be borne by society as a whole.

takings clause and the due process clause. *See* 485 U.S. at 5-6. The majority rejected the takings clause challenge as premature, since landlords had not yet suffered any actual diminution in rental income due to the challenged provision. *Id.* at 9-10. Justice Scalia, however, undertook to analyze the takings claim in detail.

Justice Scalia pointed out that, traditionally, owners of property subject to government price regulation are "singled out unfairly" to shoulder public burdens, unless their use of the property can be said to be the *source* of the social evil to be remedied. *Id.* at 20. Justice Scalia observed that:

> When commodities have been priced at a level that produces exorbitant returns, the owners of those commodities can be viewed as responsible for the economic hardship that occurs. Whether or not that is an accurate perception of the way a free-market economy operates, it is at least true that the owners reap unique benefits from the situation that produces the economic hardship, and in that respect singling them out to relieve it may not be regarded as "unfair." *Id.*

The rent control provision at issue in *Pennell* would have permitted the reduction of otherwise reasonable rents on the basis of tenant hardship. *Id.* at 5-6. The social evil the provision sought to address was not the problem of *exorbitantly* priced housing, but the problem of people too poor to afford *reasonably* priced housing. *Id.* at 21. However, as Justice Scalia observed:

> *that* problem is no more caused or exploited by landlords than it is by the grocers who sell needy renters their food, or the department stores that sell them their clothes, or the employers who pay them their wages, or the citizens of San Jose holding the higher paying jobs from which they are excluded. *Id.*
>
> (Emphasis in original.)

Rather, the problem is poverty caused by "society as a whole" and the burden of alleviating the problem should be spread over "the public at large through taxes". *Id.* He concluded that:

> unless we are to abandon the guiding principle of the Takings Clause that "public burdens . . . should be borne by the public as a whole," *Armstrong*, *supra*, at 49, 4 L Ed 2d 1554, 80 S Ct 1563, this is the only manner that our Constitution permits. *Id.* at 21-22.

Justice Scalia underscored the fact that takings in the form of price regulation are not only unfair to the subject class, but also entail "great expense to the democratic process":

> The politically attractive feature of regulation is not that it permits wealth transfers to be achieved that could not be achieved otherwise; but rather that it permits them to be achieved "off budget," with relative invisibility and thus relative immunity from normal democratic processes. *Id.* at 22.

Plainly, the fee caps currently at issue are an impermissible "off budget" transfer of wealth, which unfairly segregates anesthesiologists and requires them to bear the brunt of the cost of a social evil — the relative impecuniousness of some Medicare beneficiaries and its effect on their ability to pay for health care.

Petitioner anesthesiologists are not the source of the financial hardship of the elderly Medicare-eligible population. They were not accused by Congress of charging "exorbitant rates." Rather, the market rates for such physicians contribute to the social benefit of attracting the best and brightest to this crucial and difficult field.

At the root of this case is not physician fees so much as the abiding financial problems of some of the elderly, who are poor or of moderate income. Congress has implemented the fee caps with the laudable goal of protecting this segment of the population from medical fees they may not be able to afford. However, Congress has sought to accomplish its goal by laying this vexing problem at the doorstep of physicians such as petitioners, instead of openly and evenly distributing the cost throughout society. This approach cuts corners on the takings proscription and is constitutionally impermissible, in accordance with this Court's observation that:

> As Justice Holmes aptly noted more than 50 years ago, "a strong public desire to improve the public condition is not enough to warrant achieving the desire by a shorter cut than the constitutional way of paying for the change." *Pennsylvania Coal Co. v. Mahon*, 260 U.S. at 416, 67 L Ed 322, 43 S Ct 158, 24 ALR 1321 (1922).

First English Evangelical Lutheran Church of Glendale v. County of Los Angeles, supra, 482 U.S. at 321-22.

The Second Circuit fell into error by dismissing Justice Scalia's reasoning as a mere dissent, which, "however appealing", was not to be followed "[u]ntil Justice Scalia's view is adopted by a majority of the Court." Pet. App. at A-11. This opinion ignores the fact that, unlike the situation in *Pennell*, in which the majority found the takings claim to be premature, the petitioners here have already suffered a taking under the offending statute, by virtue of having their fees capped. Therefore, there is no ripeness issue to impede the Court here from recognizing that Justice Scalia's reasoning in *Pennell* is in perfect harmony with the fundamental principle underlying the takings clause and should be adopted.

Moreover, the Second Circuit failed to fully heed the teaching of the recent decision of this Court in *Lucas v. South Carolina Coastal Council*, ____U.S.____, 112 S.Ct. 2886 (1992), in which Justices Scalia's and O'Connor's view of the takings clause, in the context of a destruction of the economic value of real property, prevailed with the majority of the Justices on this Court.

The *Lucas* Court reinforced the bedrock notion articulated by Justice Holmes in *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393 (1922), that:

> If . . . the uses of private property were subject to unbridled, uncompensated qualification under the police power, "the natural tendency of human nature [would be] to extend the qualification more and more until at last private property disappear[ed]."

Lucas, *supra*, 112 S.Ct. at 2892-93, *quoting Pennsylvania Coal*, *supra*, 260 U.S. at 415.

Lucas therefore reconfirmed the Court's willingness to find that regulation which diminishes the value of private property can indeed amount to a taking in violation of the Fifth Amendment.[5] *Id.*

Petitioner Anesthesiologists Are Compelled to Submit to Price Regulation

It must be stressed, however, that although the disputed fee caps are a taking as applied here, petitioners do not seek to dismantle all government regulation which affects the price of goods or services. Nor do petitioners assert that the field of medicine is especially immune under the Constitution from such regulation. Rather, the unique feature which renders the fee caps a taking as applied to petitioners is the element of compulsion. This is also the factor which distinguishes this case from others which have upheld similar caps on fees chargeable to Medicare patients. *See e.g.*, *Whitney v. Heckler*, 780 F.2d at 972.[6]

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[5] Of course, the particulars of this Court's reasoning in *Lucas* are not fully applicable to the instant petition since *Lucas* involved questions peculiar to land use regulation, such as whether a regulation proscribes "a productive use [of land] that was previously permissible under relevant property and nuisance principles." 112 S.Ct. at 2901. However, *Lucas* does signify a renewed regard for the rights guaranteed by the takings clause, and a departure from the broad interpretation of cases such as *Loretto v. Teleprompter Manhattan CATV Corp.*, 458 U.S. 419, 440 (1982) and *Penn Central Transportation Co. v. City of New York*, 438 U.S. 104, 131-32 (1978), which the Second Circuit found to be in tension with *Pennell*. Pet. App. at A-11.

[6] Anesthesiologists are not speculative investors nor entrepreneurial business organizations, free to pull their capital out of a regulated industry and search for more lucrative activities. Anesthesiologists have invested years of grinding study and practice, as well as tens of thousands of dollars in medical school tuition, to master their profession. As the district court noted, their skills are their only stock in trade. Pet. App. at B-9. Unlike those who invest capital in nursing homes, anesthesiologists are not at liberty to "liquidate their holdings" and shift "positions." They are wed to their vocation and must

(Footnote continued)

This compulsion derives from New York State regulations which forbid discrimination against patients as to source of payment (10 N.Y.C.R.R. § 405.7(c)(2)), as well as the professional ethical obligation of the anesthesiologists themselves.[7] The anesthesiologists therefore *must* treat Medicare patients. In no sense do they choose to submit to the fee caps by voluntarily treating Medicare beneficiaries. Consequently, petitioner anesthesiologists stand in an analogous position to public utilities which have a duty to furnish "service on demand to all applicants" at government-determined rates. W. Pond, *The Law Governing the Fixing of Public Utility Rates: A Response to Recent Judicial and Academic Misconceptions*, 41 Admin. L. Rev. 1, 5 (1989); *see also Duquesne Light Co. v. Barasch*, 488 U.S. 299, 307 (1989).

As the Second Circuit itself noted:

> Because [such] utilities generally are compelled to employ their property to provide services to the public, the Fifth Amendment requires regulators to provide utilities with reasonable compensation for their services. *See Minnesota Ass'n*, 742 F.2d at 446; *see also* Pond, *supra*, at 5. Pet. App. at A-7.

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practice to receive a "return" on their investment. If petitioner anesthesiologists withdraw from practice to avoid the fee caps, their investment in becoming anesthesiologists is totally lost (and, incidentally, the availability of anesthesia care to the public decreases). Their position, therefore, is simply not comparable to the nursing home owners involved in *Minnesota Ass'n of Health Care Facilities, Inc. v. Minnesota Dept. of Pub. Welfare*, 742 F.2d 442 (8th Cir.), *cert. denied*, 469 U.S. 1215 (1985), relied on by the Second Circuit in the instant case. Pet. App. at A-10.

[7] The Second Circuit held that the anesthesiologist's professional ethical obligation precluding them from refusing treatment to Medicare patients outside of hospitals, is a "self-imposed requirement [which] do[es] not constitute the kind of governmental compulsion that may give rise to a taking." Pet. App. at A-10. As noted *infra*, n.9, there is no requirement under *Bowles* that the compulsion be directly imputed to the government, so long as the consequential taking is of government origin. It is the anesthesiologist's ethical obligation which constitutes the *compulsion* to treat all Medicare patients out of hospital and the federal fee cap which constitutes the *taking* as applied under the circumstances. State regulations supply the compulsion for services within the hospital.

Despite this constitutional requirement, petitioners in the instant case have received *no* compensation from the regulators for the fees they have been forbidden to collect.

Unfortunately, the Second Circuit erroneously failed to perceive compulsion in the present case, based largely on its unfounded assertion that *state law* and *professional ethical* duties compelling treatment of Medicare patients, are not sufficiently compulsory to render petitioners' subjection to *federal* fee caps involuntary. Pet. App. at A-9.[8]

This position is without basis in any of this Court's precedent or that of any other authority known to petitioners. Moreover, it disregards the inescapable fact that it is the *federal* fee caps which destroy a portion of the value of petitioner's services.[9] The Second Circuit relies on a distinction which makes no difference to the affected petitioners and which is therefore too slender a reed to support deprivation of a vital constitutional right. Consequently, the fee caps at issue are in direct violation of the Fifth Amendment's prohibition of uncompensated taking of private property for the public use.

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[8] The Second Circuit's opinion that the "anesthesiologists, like the landlords in *Bowles [v. Willingham*, 321 U.S. 503 (1944)] and unlike public utilities, are under no legal duty to provide services to the public and to submit to price regulation," misses the point. Pet. App. at A-8. The issue here is whether the anesthesiologists are legally or ethically bound to treat Medicare patients. Moreover, the *Bowles* decision is plainly distinguishable from the case at bar. Unlike petitioner anesthesiologists, those landlords in *Bowles* who chose not to subject themselves to the emergency wartime rent control provisions might have simply waited until the controls expired to enter the rental market.

[9] The Second Circuit's suggestion (Pet. App. at A-9) that it is New York State, rather than the federal government, that "indirectly compels anesthesiologists to treat Medicare patients and thus submit to price regulations. . . ." is misguided. *Bowles* does not state that the federal government must compel the activity which constitutes the taking. The federal fee cap combined with the anesthesiologists' pre-existing legal and ethical obligations results in the compulsion. In the absence of the federal price control, there is no taking. Therefore, the New York State requirement that anesthesiologists cannot refuse to treat Medicare patients (10 N.Y.C.R.R. § 405.7(c)(2)) is not the offending government regulation — the Medicare fee cap is.

CONCLUSION

The petition for a writ of certiorari should be granted.

Dated: New York, New York
June 2, 1993

Respectfully submitted,

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UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 215—August Term, 1992

(Argued: October 8, 1992 Decided: March 5, 1993)

Docket No. 92-6100

BERTHA GARELICK; YOLANDA RESTAINO; ELENA SAVINO; DAVID ATKINSON; BRUCE KONRAD; PETER T. PICKERING,

Plaintiffs-Appellants,

—v.—

LOUIS W. SULLIVAN, M.D., Secretary of the U.S. Department of Health and Human Services; WILLIAM TOBY, Administrator, Health Care Financing Administration, Region II,

Defendants-Appellees.

Before:

VAN GRAAFEILAND, PRATT and WALKER,

Circuit Judges.

Appeal from a judgment entered in the United States District Court for the Southern District of New York,

William C. Conner, *Judge*, granting defendants-appellees' motion for summary judgment dismissing plaintiffs-appellants' complaint bringing Fifth Amendment challenges to Medicare Part B limiting charge provisions. 784 F. Supp. 108 (S.D.N.Y.), *reconsideration granted in part*, No. 91 Civ. 4524, 1992 WL 71946 (Mar. 24, 1992 S.D.N.Y.).

Affirmed.

WHITNEY NORTH SEYMOUR, JR. (Craig A. Landy, Peter James Clines, Brown & Seymour, New York City, of counsel), for *Plaintiffs-Appellants*.

LINDA A. RIFFKIN, Special Assistant United States Attorney (Otto G. Obermaier, United States Attorney for the Southern District of New York, Paul K. Milmed, Assistant United States Attorney, of counsel), for *Defendants-Appellees*.

WALKER, *Circuit Judge*:

The central questions presented by this appeal are whether a federal statutory scheme designed to control Medicare costs has caused a taking of property from plaintiff anesthesiologists requiring compensation under the Fifth Amendment and whether plaintiff limited-income Medicare beneficiaries have standing to assert a constitutional challenge to the statutory scheme based upon increased physician medical charges allegedly caused by the cost control measures

BACKGROUND

Medicare is the federal medical insurance program for disabled persons and those 65 and older. *See* 42 U.S.C. § 1395, *et seq*. The Medicare program is composed of two parts, A and B. Part A provides insurance for the cost of hospitalization and related services, and is funded out of Social Security taxes. *See id.* at §§ 1395c-1395i-4. Part B, the exclusive focus of this appeal, is a voluntary program that provides Medicare beneficiaries with supplemental benefits. *See id.* at §§ 1395j-1395w-4. Part B beneficiaries pay monthly premiums that, along with federal government contributions, are remitted to the Federal Supplementary Medical Insurance Trust Fund. *See id.* at § 1395t. The Department of Health and Human Services has responsibility for administering the program, and contracts with private insurance carriers who evaluate and pay Part B claims out of the Trust Fund. *See id.* at § 1395u.

If the carrier finds that a claim is reimbursable, Medicare pays 80% of the Medicare-defined allowed or "reasonable" charge for the claim. *See id.* at § 1395l(a)(1); *see also* 42 C.F.R. § 405.501, *et seq*. The beneficiary is responsible for a "copayment" of the remaining 20% of the allowed charge.

Part B provides physicians with two payment options. They can choose to "accept assignment," which means that they bill Medicare directly for their services and accept the allowed charge as full payment, receiving 80% from Medicare and 20% from the beneficiary. *See* 42 U.S.C. § 1395u(b)(3)(B)(ii). Alternatively, a physician may choose to bill the patient directly for 100% of their charge, with Medicare reimbursing the patient for 80% of the Medicare reasonable charge. *See id.* at §§ 1395l(a)(1),

1395u(b)(3)(B)(i). A physician who does not accept assignment may charge her patient in excess of the Medicare allowed charge, a practice called "balance billing."

In recent years, Congress has enacted a series of statutes designed to discourage and limit balance billing and encourage physicians to accept assignment. The Deficit Reduction Act of 1984 ("DEFRA") created the "Participating Physicians Program," requiring physicians to decide on an annual basis whether to enter into "participation agreements." During the term of a participation agreement, a participating physician agrees to accept assignment for all items and services she provides under Part B and is precluded from balance billing. *See id.* at § 1395(u)(h)(1). Under DEFRA, a non-participating physician retained the option of accepting or refusing assignment in individual cases. However, DEFRA provided incentives for physicians to enter into participation agreements. For example, the statute temporarily froze the fees non-participating physicians could charge Medicare patients. *See id.* at § 1395u(j)(1)(A); *Pennsylvania Medical Soc'y v. Marconis*, 942 F.2d 842, 844 (3d Cir. 1991).

The Omnibus Budget Reconciliation Act of 1986 ("OBRA-86") lifted the DEFRA freeze on non-participating physician fees, substituting a system of "maximum allowable actual charges" ("MAACs") for services. *See* 42 U.S.C. § 1395u(j)(1)(B)(i). MAACs were initially based upon physicians' actual charges for the quarter beginning on April 1, 1984. *See id.* at § 1395u(j)(1)(C)(iv). Under OBRA-86, non-participating physicians were not permitted to charge Part B beneficiaries in excess of MAAC rates, unless their annual average fees fell below levels set forth in the statute. *See* Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. 1874 (1986); H.R. Conf. Rep. No. 1012, 99th Cong., 2d

Sess. 330-31, *reprinted in* 1986 U.S.C.C.A.N. 3868, 3975-76.

The Omnibus Budget Reconciliation Act of 1989 ("OBRA-89"), included provisions designed to further "protect [Medicare] beneficiaries against excessive balance billing" by non-participating physicians. H.R. Rep. No. 247, 101st Cong., 1st Sess. 348, *reprinted in* 1989 U.S.C.C.A.N. 1906, 2074. OBRA-89 replaced the MAAC formula with a concept called the "limiting charge," which limits non-participating physicians' charges to set percentages of the Medicare-defined allowed charge for services. *See* 42 U.S.C. § 1395w-4(g)(2). The limiting charge is now 115% of the allowed charges for services. *See id.* at § 1395w-4(g)(2)(C).

It is OBRA-89's limiting charge scheme that plaintiff New York hospital-based anesthesiologists and limited-income Part B beneficiaries challenge. The anesthesiologists assert that the limiting charge regime gives rise to a taking of property without just compensation in violation of the Fifth Amendment. They also purport to assert a substantive due process claim, but in their briefs to this court fail to distinguish this claim from their takings claim, and thus it will not be independently considered. The beneficiaries challenge the scheme as violative of the equal protection and substantive due process components of the Fifth Amendment. Plaintiffs seek, *inter alia*, declaratory and injunctive relief.

The district court granted defendants' summary judgment motion and dismissed the entire complaint. The court found the anesthesiologists' claims invalid as a matter of law. *See Garelick v. Sullivan*, 784 F. Supp. 108, 112-14 (S.D.N.Y. 1992), *reconsideration granted in part*, No. 91 Civ. 4524, 1992 WL 71946 (Mar. 24, 1992 S.D.N.Y.).

The court also found that the beneficiaries lacked standing to challenge the statutory scheme. *See id.* at 111-12. We agree with both decisions.

DISCUSSION

I. *The Anesthesiologists' Claims*

Government has broad power to regulate the use of property; but this power is constrained by constitutional limits. *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393, 413-15 (1922). It is well established that the Takings Clause of the Fifth Amendment applies to so-called "regulatory takings." The anesthesiologists contend that the OBRA-89 limiting charge scheme is a regulatory taking of their property interests in their licenses and practices as physicians. Their primary argument is that they have been compelled to provide services to Medicare Part B patients, and thus to submit to price regulations imposed by the statutory scheme. They also argue that the governmental purpose behind the limiting charge provisions—allegedly to ameliorate the burden of increasing medical costs upon elderly and disabled Medicare beneficiaries by decreasing compensation to physicians—renders the scheme a taking. In light of prevailing Supreme Court case law, we reject both theories.

A property owner must be legally compelled to engage in price-regulated activity for regulations to give rise to a taking. *See Bowles v. Willingham*, 321 U.S. 503, 517-18 (1944); *Whitney v. Heckler*, 780 F.2d 963, 972 (11th Cir.), *cert. denied*, 479 U.S. 813 (1986); *Minnesota Ass'n of Health Care Facilities v. Minnesota Dep't of Pub. Welfare*, 742 F.2d 442, 446 (8th Cir. 1984), *cert. denied*, 469 U.S. 1215 (1985). For example, public utilities are under a

state statutory duty to serve the public, and must furnish "service on demand to all applicants" at government-determined rates. W. Pond, *The Law Governing the Fixing of Public Utility Rates: A Response to Recent Judicial and Academic Misconceptions*, 41 Admin. L. Rev. 1, 5 (1989) (hereinafter "Pond"); *see also Duquesne Light Co. v. Barasch*, 488 U.S. 299, 307 (1989). Because utilities generally are compelled to employ their property to provide services to the public, the Fifth Amendment requires regulators to provide utilities with reasonable compensation for their services. *See Minnesota Ass'n*, 742 F.2d at 446; *see also* Pond, *supra*, at 5.

By contrast, where a service provider voluntarily participates in a price-regulated program or activity, there is no legal compulsion to provide service and thus there can be no taking. *See Bowles*, 321 U.S. at 517-18; *Burditt v. United States Dep't of Health and Human Servs.*, 934 F.2d 1362, 1376 (5th Cir. 1991); *Whitney*, 780 F.2d at 972; *Minnesota Ass'n*, 742 F.2d at 446; *Texaco Puerto Rico, Inc. v. Ocasio Rodriguez*, 749 F. Supp. 348, 359 (D.P.R. 1990); *Anco, Inc. v. State Health and Human Servs. Fin. Comm.*, 300 S.C. 432, 441-42, 388 S.E.2d 780, 786 (1989). Thus, in *Bowles v. Willingham*, the Supreme Court sustained a rent regulation ordinance because the statute did not require that plaintiff landlords remain in the business of renting apartments. The landlords were free to keep their buildings vacant and/or to dispose of their properties on the market (albeit at prices depressed by the rent regulations) without being subject to government price regulations. Consequently, the statute at issue did not give rise to a regulatory taking. *See* 321 U.S. at 517-18; *see also St. Francis Hosp. Ctr. v. Heckler*, 714 F.2d 872, 884 (7th Cir. 1983) (per curiam) (diminishment of market value resulting from regulation will not give rise

to taking where property owner retains "full rights and control over . . . net investment"), *cert. denied*, 465 U.S. 1022 (1984).

The anesthesiologists, like the landlords in *Bowles* and unlike public utilities, are under no legal duty to provide services to the public and to submit to price regulations. The OBRA-89 limiting charge provisions do not require anesthesiologists, or any other physicians, to provide services to Medicare beneficiaries. The challenged provisions simply limit the amounts non-participating physicians, anesthesiologists in this case, may charge those Medicare beneficiaries whom they choose to serve. They retain the right to provide medical services to non-Medicare patients free of price regulations. Because they voluntarily choose to provide services in the price-regulated Part B program, the plaintiff anesthesiologists do not have a viable takings claim.

All court decisions of which we are aware that have considered takings challenges by physicians to Medicare price regulations have rejected them in the recognition that participation in Medicare is voluntary. For example, in *Whitney*, the Eleventh Circuit rejected a challenge to the temporary fee freeze imposed upon non-participating physicians under DEFRA, reasoning that "[i]t is well established that government price regulation does not constitute a taking of property where the regulated group is not required to participate in the regulated industry." 780 F.2d at 972; *see, e.g., Metrolina Family Practice Group, P.A. v. Sullivan*, 767 F. Supp. 1314, 1322 (W.D.N.C. 1989) (upholding elements of DEFRA and OBRA-86 price regulations applicable to non-participating physicians; citing cases), *aff'd*, 929 F.2d 693 (4th Cir. 1991); *American Medical Ass'n v. Bowen*, 659 F. Supp. 1143, 1150 (N.D. Tex. 1987) (denying equitable relief in challenge to

OBRA-86 price regulations; citing cases), *appeal dismissed and judgment vacated on other grounds*, 857 F.2d 267 (5th Cir. 1988); *see also Burditt*, 934 F.2d at 1376 (rejecting physician's challenge to penalty imposed pursuant to federal statute requiring Medicare-participating hospitals to treat patients entering emergency rooms).

The anesthesiologist plaintiffs argue that these cases are inapposite because New York law compels them to render services to Medicare beneficiaries. New York requires hospitals to afford each patient the right to treatment without discrimination as to the source of payment. *See Patients' Bill of Rights*, 10 NYCRR § 405.7(c)(2). For the purposes of this discussion, we accept the anesthesiologists' contention that this provision legally requires hospitals to accept Medicare patients. The anesthesiologists contend that this legal compulsion extends to them, requiring hospitals to mandate that all physicians on their staffs treat Medicare patients. In the first place, we are not persuaded that the anesthesiologists have correctly construed the New York statute, which does not on its face apply to individual physicians. However, even if their interpretation of § 405.7(c)(2) is correct, it does not support a takings challenge to the OBRA-89 limiting charge scheme. Under the anesthesiologists' theory, it is New York State—which is not a party to this action—that indirectly compels anesthesiologists to treat Medicare patients and thus submit to price regulations, not the federal government.

Moreover, even if the alleged compulsion to serve Medicare patients were imputed to the federal government, the plaintiff anesthesiologists' takings claim would fail. Under the anesthesiologists' interpretation of the *Patients' Bill of Rights*, physicians are required to provide services to Medicare beneficiaries only if they practice in

hospitals. Therefore, anesthesiologists can avoid treating Medicare beneficiaries by practicing on an outpatient basis. The anesthesiologists argue that limiting themselves to outpatient practices is not an economically viable option, since most procedures requiring their services are performed in hospitals; yet, as the law presently stands, economic hardship is not equivalent to legal compulsion for purposes of takings analysis. *See, e.g., Minnesota Ass'n*, 742 F.2d at 446 (rejecting challenge by nursing home operators to a state statute that conditioned receipt of Medicaid funds upon acceptance of across-the-board price regulations; reasoning that while plaintiffs were under a "strong financial inducement to participate in Medicaid", they were not under a legal compulsion to do so); *see also Idaho Health Care Ass'n v. Sullivan*, 716 F. Supp. 464, 472 (D. Idaho 1989) (rejecting due process challenge to nursing home admission regulations applicable to nursing homes participating in Medicaid; noting that "[d]espite the financial benefits available to a participant in Medicaid, the nursing homes' decision to come under the system is nonetheless voluntary.").

The anesthesiologists also contend that their professional ethical rules preclude them from refusing treatment to Medicare patients outside of hospitals. However, such self-imposed requirements do not constitute the kind of governmental compulsion that may give rise to a taking.

The plaintiff anesthesiologists assert a second takings argument grounded in the public interest allegedly served by the OBRA-89 limiting charge scheme. In his dissent in *Pennell v. San Jose*, 485 U.S. 1 (1988), Justice Scalia argued that where a price regulation is designed to ameliorate or cure a social ill that the regulated property owner has neither contributed to nor created, the regulation gives rise to a taking. *See id.* at 18-24 (Scalia, J., con-

curring in part and dissenting in part). The anesthesiologists argue that the OBRA-89 limiting charge scheme was directed toward "alleviating the national problem of elderly patients who do not have the means to afford to pay medical bills." Because they are not the source of the social ill that Congress allegedly sought to address through the limiting charge provisions, the anesthesiologists reason that the statutory scheme gives rise to a taking under the logic of the *Pennell* dissent. However, Justice Scalia's dissent was just that; a majority of the Supreme Court has yet to adopt Justice Scalia's reasoning, which, however appealing, is in tension (if not conflict) with well established Fifth Amendment doctrine granting government broad power to determine the proper subjects of and purposes for regulatory schemes. *See, e.g., Loretto v. Teleprompter Manhattan CATV Corp.*, 458 U.S. 419, 440 (1982) (Supreme Court has "consistently affirmed that States have broad power to regulate housing conditions in general and the landlord-tenant relationship in particular without paying compensation for all economic injuries that such regulation entails"); *Penn Cent. Transp. Co. v. City of New York*, 438 U.S. 104, 131-32 (1978) (refusing to invalidate municipal landmarks law designed to preserve historic structures on ground that statute singled out certain landowners for financial hardship); *but see Lucas v. South Carolina Coastal Council*, 112 S. Ct. 2886, 2893 (1992) (regulation that deprives property owner of "all economically beneficial or productive use of [her] land" constitutes compensable taking unless prohibited activity amounts to nuisance under relevant state law doctrine). Until Justice Scalia's view is adopted by a majority of the Court, this takings theory must fail.

II. *The Beneficiaries' Claims*

Before the first Medicare fee caps were imposed, non-participating physicians were free to obtain market-rate fees from high-income patients by "balance billing" them well in excess of the 20% of allowed or "reasonable charges" not paid by Medicare. At the same time, plaintiff beneficiaries contend, physicians charged lower fees to limited-income beneficiaries, effectively subsidizing their services to those patients with the high fees paid by beneficiaries with greater abilities to pay. However, according to the plaintiff beneficiaries, with the institution of the fee caps, non-participating physicians no longer subsidize their services to limited-income Medicare beneficiaries with high charges to more well-to-do beneficiaries; instead, they charge all beneficiaries the same maximum allowable amounts.

The beneficiaries argue that Congress failed to "meaningfully protect" them from the increasing burden of medical costs when it enacted the OBRA-89 limiting charge provisions. They claim that the statutory scheme violates the Fifth Amendment's equal protection and substantive due process guarantees because it arbitrarily and discriminatorily induces non-participating physicians to impose a greater economic burden upon limited-income than high-income beneficiaries by charging all patients the same fees regardless of their relative abilities to pay.

The district court did not reach the merits of the beneficiary plaintiffs' claims on the ground that they lack standing to assert their constitutional claims. We agree.

The doctrine of standing incorporates both constitutional and prudential limitations upon the jurisdiction of

federal courts. At a minimum, Article III of the Constitution requires a party invoking federal jurisdiction to establish:

> (1) personal injury or threat of injury; (2) that the injury fairly can be traced to the action challenged; and (3) that the injury is likely to be redressed by the requested relief.

Heldman v. Sobol, 962 F.2d 148, 154 (2d Cir. 1992); *see Valley Forge Christian College v. Americans United for Separation of Church and State, Inc.*, 454 U.S. 464, 472 (1982); *Lamont v. Woods*, 948 F.2d 825, 829 (2d Cir. 1991).

The beneficiaries have satisfied the first prong of the standing test; they submitted evidence tending to prove that doctors have billed them the full amounts of Medicare allowed charges following the implementation of the OBRA-89 limiting charge scheme. However, the beneficiaries have not offered evidence that could establish a sufficient causal nexus between the challenged government actions and their injuries. Thus, the second prong of the Article III standing test is unsatisfied, and we need not reach the redressability prong.

The causation component of the Article III standing test insures that the injury alleged by a plaintiff is attributable to the defendant. "The critical issue in applying the causation requirement is what constitutes a sufficient causal nexus for standing." *Heldman*, 962 F.2d at 156. The plaintiff's injury—in this case, the beneficiaries' increased medical bills—must be fairly traceable to the allegedly illegal government conduct, here the limiting charge scheme implemented under OBRA-89.

A plaintiff does not lack standing merely because her injury is an indirect product of the defendant's conduct. *See, e.g., Meese v. Keene*, 481 U.S. 465, 472-77 (1987) (potential distributor of foreign films has standing to challenge Justice Department's characterization of films as "political propaganda" since it would affect his reputation and harm his chances for reelection to public office); *Heldman*, 962 F.2d at 156 (injury to child by third-party school board which implemented state regulations supports standing to sue state officials). However, to survive a motion for summary judgment, a plaintiff must proffer facts establishing that all links in the causal chain are satisfied. *Cf. Allen v. Wright*, 468 U.S. 737, 757-58 (1984) (in order to prevail in response to motion to dismiss on standing grounds, plaintiff must allege facts constituting all elements of causal chain).

In *Allen v. Wright*, plaintiff parents of black public school students enrolled in school districts undergoing desegregation challenged the Internal Revenue Service's provision of tax exemptions to private segregated schools. The parents contended that the tax exemptions violated their children's rights to be educated in desegregated schools by lowering the cost of segregated private school education and thus encouraging white parents to send their children to the private schools. The Court found, however, that the children's injury " 'result[ed] from the independent action of some third party not before the court' " and denied the parents standing. *Id.* at 757 (quoting *Simon v. Eastern Kentucky Welfare Rights Org.*, 426 U.S. 26, 42 (1976)). In finding plaintiffs were without standing, the Court stated that:

> it is entirely speculative . . . whether withdrawal of a tax exemption from any particular school would lead the school to change its policies. . . . It is just

> as speculative whether any given parent of a child attending such a private school would decide to transfer the child to public school as a result of any changes in educational or financial policy made by the private school once it was threatened with loss of tax exempt status.

Id. at 758.

Here, as in *Allen*, there is a crucial "missing link" in the chain of events allegedly giving rise to plaintiffs' injuries. The beneficiaries have failed to provide facts tending to prove that the implementation of OBRA-89's limiting charge scheme caused their physicians to choose to increase the beneficiaries' bills. Moreover, even if some physicians chose to increase their charges to limited-income patients in response to the limiting charge scheme, the plaintiff beneficiaries probably would still lack standing. Any increases in the amounts charged to limited-income patients would be the product of independent choices by physicians from among a range of economic options, like the decisions of the parents of private school students and private school administrators in *Allen*, not a necessary product of the challenged legislative scheme. Because the beneficiary plaintiffs have failed to establish that their injuries are fairly traceable to the limiting charge scheme, they lack standing to assert their claims.

CONCLUSION

The judgment of the district court is affirmed.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

BERTHA GARELICK, YOLANDA RESTAINO, ELENA SAVINO, DAVID ATKINSON, BRUCE KONRAD and PETER T. PICKERING,

Plaintiffs,

— against —

LOUIS W. SULLIVAN, as Secretary of the Department of Health and Human Services, and WILLIAM TOBY, as Administrator, Health Care Financing Administration, Region II,

Defendants.

91 Civ. 4524 (WCC)

OPINION AND ORDER

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CONNER, D. J.:

In this action for declaratory judgment and preliminary and permanent injunctive relief, plaintiffs, three hospital-based anesthesiologists and three patients enrolled in Medicare Part B, challenge the constitutionality of section 6102(a) of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (codified at 42 U.S.C. § 1395w-4(g)) ("OBRA-89"). This provision sets limits on the amounts that physicians may charge Medicare patients for their services. The action is currently before the Court on plaintiffs' motion for summary judgment as to all claims and on defendants' cross-motion for summary judgment dismissing plaintiffs' claims.

BACKGROUND

The Medicare program is comprised of two parts — Part A and Part B. Part A, which is not implicated in the instant case, provides institutional health coverage for hospital care and related post-hospitalization services. Part B of the Medicare Act, 42 U.S.C. §§ 1395j-1395w, is a federally subsidized, voluntary program of supplemental medical insurance which covers, in general, 80% of the reasonable cost of certain medical expenses that are excluded from the Part A program.

Under Part B, Medicare enrollees obtain benefits in return for the payment of monthly premiums in an amount determined by the Secretary of Health and Human Services. *See id.* § 1395r(b)-(c); § 1395(t). These premiums, together with contributions from the federal government, make up the Federal Supplementary Medical Insurance Trust Fund (the "Trust Fund"). *Id.* § 1395t.

Physicians may routinely accept assignment of claims for treatment of Part B Medicare patients, or may accept assignment of Medicare claims on a selective basis, or may refuse to accept assignment of any Medicare claims. Physicians who do accept assignment of claims for services rendered under Part B agree to accept the charges approved by Medicare in full satisfaction for their services and submit claims and receive reimbursement

directly from the carrier under the Part B program. When a claim is unassigned, that is, when a physician does not accept assignment, the physician is obligated to prepare and submit the Medicare claim form to the carrier on behalf of the patient, but the carrier then sends reimbursement directly to the patient. On such unassigned claims the physician looks directly to the patient or his or her private insurance carrier for payment.

In 1984, Congress enacted a sweeping cost-control provision in Section 2306 of the Deficit Reduction Act, Pub. L. No. 98-369, 98 Stat. 494 ("DEFRA") (codified at 42 U.S.C. § 1395u(h)). Prior to DEFRA, all physicians were permitted to decide on a claim-by-claim basis whether or not to accept assignment of Medicare claims. If a physician chose not to accept assignment, Medicare placed no limitation on the amount that he or she could charge a Medicare beneficiary. Medicare reimbursement, however, was limited to a "reasonable charge" as determined by Medicare, leaving the beneficiary responsible for the difference between the physician's actual charge and the Medicare reimbursement.

DEFRA altered the previous system by requiring physicians to indicate each year whether they would be Medicare "participating" or "non-participating" physicians. *See* 42 U.S.C. § 1395u(h). A participating physician was defined as one who agreed, for the period of participation, to accept assignment of his patients' right to reimbursement and to accept the Medicare reasonable charge as payment in full for all items or services furnished to Medicare beneficiaries. A non-participating physician was defined as one who decides on an individual basis whether to accept such assignment or to bill the patient directly. DEFRA froze the fees the non-participating physicians could charge Medicare beneficiaries at the level of the physician's "actual charges" for the calendar quarter beginning April 1, 1984.

In the health care provisions of the Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. 1874 ("OBRA-86"), Congress further restricted the amounts non-participating physicians could charge Medicare beneficiaries. Section 9331 of OBRA-86 effectively replaced the DEFRA fee

freeze by limiting non-participating physicians' charges to Medicare beneficiaries in accordance with a formula called the physician's "Maximum Allowable Actual Charge" ("MAAC"). The MAAC as originally enacted was based on the physician's actual charges for the second quarter of 1984 but was subject to adjustment in limited circumstances after administrative review. *See* 42 U.S.C. § 1395ff.

The health care provisions of OBRA-89 mandate the conversion of the Medicare reimbursement system to one based on a Medicare fee schedule, incorporating a "relative value scale" and an annual "conversion factor" instead of employing prevailing fees. 42 U.S.C. § 1395w-4(a). Section 6102(a) of OBRA-89 effectively replaces the MAAC fee limitation formula with a different concept called the "limiting charge." 42 U.S.C. § 1395w-4(g). Under this concept, as of January 1, 1991, physicians who do not accept assignment of Medicare approved amounts in full satisfaction of their fees are, in most instances, prohibited from charging any Medicare patient more than 125% of the fee allowed by Medicare for the services rendered.

Beginning January 1, 1992, the "recognized payment" or reimbursed portion of the fee for a physician's service to a Medicare patient is determined on the basis of a number of criteria, including the "relative value" for the service as determined under OBRA-89 section 6102(c)(2), the "conversion factor" for the year established under subsection (d), and the "geographic adjustment factor" for the service for the fee schedule area established under subsection (e)(2). 42 U.S.C. § 1395w-4(b)(1). Under section 6102(a), effective January 1992, the limiting charge may not be higher than 120% of the recognized payment amount, and after 1992, the limiting charge may not be higher than 115% of the recognized payment amount. 42 U.S.C. § 1395w-4(g)(2).

Physicians whose charges exceed the limiting charge are subject to sanctions which include penalties of up to $2,000 per violation plus twice the amount claimed for the service in accordance with 42 U.S.C. § 1842(j)(2). *See* 42 U.S.C. § 1395w-4(g)(1).

Plaintiffs contend that the limiting charge restriction, as applied to hospital-based anesthesiologists, is unconstitutional because it is arbitrary and discriminatory, and because it is demonstrably irrelevant to valid Congressional policy. Plaintiffs further contend that the limiting charge restriction violates the due process clause and equal protection component of the Fifth Amendment and violates that Fifth Amendment prohibition against the taking of private property for public use without just compensation.

DISCUSSION

I. Applicable Legal Standard

Summary judgement is appropriate where no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). In the instant case, there is little dispute over the material facts. While the parties do dispute several points of law, legal questions present nothing for trial and are appropriately resolved on a motion for summary judgment. *See Holland Industries, Inc. v. Adamar of New Jersey Inc.*, 550 F. Supp. 646 (S.D.N.Y. 1982); *Flair Broadcasting Corp. v. Powers*, 733 F. Supp. 179 (S.D.N.Y. 1990). The Court thus decides the parties' motions as a matter of law.

II. Standing

Defendants challenge standing as to the three plaintiff patients. The plaintiff patients, Bertha Garelik, Yolanda Restaino, and Elena Savino, allege that the fee restrictions of section 6102(a) of OBRA-89 violate their rights under a number of constitutional provisions, including the equal protection component and the due process clause of the Fifth Amendment.

The Supreme Court has summarized the elements of standing as follows:

> [A]t an irreducible minimum Art. III [of the Constitution] requires the party who invokes the court's authority to "show that he personally has suffered

> some actual or threatened injury as a result of the putatively illegal conduct of the defendant," *Gladstone Realtors v. Village of Bellwood*, 441 U.S. 91, 99 (1979), and that the injury "fairly can be traced to the challenged action" and "is likely to be redressed by a favorable decision," *Simon v. Eastern Kentucky Welfare Rights Org.*, 426 U.S. 26, 38, 41 (1976).

Valley Forge Christian College v. Americans United for Separation of Church and State Inc., 454 U.S. 464, 472 (1982) (footnote omitted).

Defendants aver that the plaintiff patients do not satisfy these criteria because they have not alleged any actual or threatened injury that "fairly can be traced" to the actions of defendants. Defendants note that the injury that these patients assert is that the statute forces limited-income beneficiaries who are treated by non-participating anesthesiologists to accept liability for payment of an additional 25% in fees above the amount they would owe if non-participating anesthesiologists were free to charge higher fees to wealthier Medicare patients and thereby subsidize their charging of lower fees or acceptance of assignment in the case of poorer patients. *See* Complaint, ¶¶ 27, 28, 30, 32, 34, 35.

The essence of defendants' argument is that it is an entirely speculative proposition that, because of the limiting charge, anesthesiologists who would otherwise do so will not charge lower fees or accept assignment of poorer patients. Defendants maintain that the statute does not force anesthesiologists to collect the full 25% above the Medicare fee level; the statute simply limits the fees that anesthesiologists and other physicians may charge their Medicare patients. Thus, defendants maintain that while the fee reduction may lead some anesthesiologists to require the full charge from all patients, the decision to do so will have been made independently by each anesthesiologist and necessarily involves a choice among a range of alternatives. Defendants conclude that because the decision to charge the full 25% is discretionary on the part of the individual physician and not required by the statute, plaintiffs may not rely upon the statute to obtain standing. The Court agrees.

Where an injury results from the "independent action of a third party," the causal link between the plaintiff's injury and the defendant's conduct is too attenuated to establish standing to sue. *Allen v. Wright*, 468 U.S. 737, 757-59 (1984). As one court has noted in dismissing a challenge by patient plaintiffs to the DEFRA fee freeze:

> Federal courts cannot entertain claims which are founded on sheer speculation as to what may or may not happen under particular circumstances. This Court may only hear those disputes which are real, immediate, and concrete, that is, cases or controversies. This Court cannot rely on promises or threats of future action vaguely contingent upon the outcome of certain other events or decisions; it cannot rely on mere possibilities of fact.

American Medical Ass'n v. Heckler, 606 F. Supp. 1422, 1435 (S.D. Ind. 1985).

Plaintiffs have cited *Cosgrove v. Bowen*, No. 85 Civ. 4472 (S.D.N.Y) (Oct. 31, 1988), an unreported decision, as their only support for standing. That case does not address the standing issue[1] and is therefore unpersuasive. Given the speculative nature of the patient plaintiffs' claims as to the effect of section 6192(a) upon them, the Court finds that these plaintiffs lack standing in the instant case.[2]

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[1] Moreover, the plaintiff patients in *Cosgrove* challenged a regulation, 42 C.F.R. § 405.551(e), as unlawful because it reduced by two-thirds the Medicare reimbursement they would otherwise have been entitled to receive. *See Cosgrove v. Bowen*, 649 F. Supp. 1433, 1436 (S.D.N.Y. 1986) (earlier opinion in same case). That case is thus readily distinguishable since the injury alleged did not result from the independent action of a third party.

[2] Because the Court finds that the plaintiff patients lack standing, the Court does not consider plaintiff patients' Fifth Amendment due process and equal protection claims.

II. Substantive Due Process Claim.

Plaintiff doctors challenge the constitutionality of section 6102(a) on substantive due process grounds, arguing that the statute forces hospital-based anesthesiologists to accept a fee limitation in every case in which the patient is enrolled in Medicare despite the fact that the anesthesiologists are not free to refuse to treat Medicare patients. Complaint ¶ 27.

The test for determining whether economic and social regulation meets substantive due process requirements is well established: "[i]f the laws passed are seen to have a reasonable relation to a proper legislative purpose, and are neither arbitrary nor discriminatory, the requirements of due process are satisfied. . . ." *Nebbia v. New York*, 291 U.S. 502, 537 (1934). As the Eleventh Circuit observed in *Whitney v. Heckler*, 780 F.2d 963 (11th Cir. 1986), Congress intended to accomplish two objectives in enacting DEFRA § 2306: First, in order to curtail the increase in the federal deficit, Congress effected a fifteen-month freeze in the amounts paid by Medicare for physicians' services. Second, in order to ensure that non-participating physicians would not make up any profits lost as a result of the freeze by raising their non-reimbursed charges to Medicare patients, Congress placed a ceiling on the amount non-participating physicians could charge such patients. *See Whitney*, 780 F.2d at 969-70. Finding DEFRA §2306 reasonably related to these proper legislative purposes, the Eleventh Circuit dismissed plaintiffs' due process challenge. *See id.* at 971. *See also American Soc. of Cataract & Refractive Surgery v. Bowen*, 725 F. Supp. 606 (D.D.C. 1989) (rejecting due process challenge to constitutionality of sections 9331 and 9334 of OBRA-86); *American Medical Ass'n v. Heckler*, 606 F. Supp. 1422 (S.D. Ind. 1985) (rejecting due process challenge to DEFRA § 2306).

Plaintiffs' due process challenge to section 6102(a) of OBRA-89 cannot be meaningfully distinguished from the due process challenges against DEFRA and OBRA-86 by the plaintiff doctors in *Whitney* and the other cases cited above. As defendants note, OBRA-89 extends the restrictions on physician charges enacted in section 9331 of OBRA-86, adopting the same

approach of limiting Medicare payments for physician services while protecting Medicare beneficiaries from cost shifting by physicians. *See* H. Rep. No. 101-247, 101st Cong., 1st Sess. 348, *reprinted in* 1989 U.S. Code Cong. & Admin. News 1906, 2074. Thus, section 6102(a) of OBRA-89, like its predecessors, bears a reasonable relationship to Congress's goal of preventing Medicare beneficiaries from carrying the burden of the reduction of Medicare expenditures. The Court therefore grants defendants' motion to dismiss plaintiffs' due process claims.

III. Fifth Amendment Takings Claim

Plaintiffs argue strenuously that in the instant case, Congressional price control of private physician fees is a taking of private property without just compensation. If the Court were writing on a clean slate, that argument might have considerable logical force. Plaintiffs have invested substantial amounts of time and money in their medical education and training, and their expert services are their only stock in trade. If they are compelled by existing contracts with hospitals to supply these services to Medicare patients at below-market prices, a portion of their asset value would be confiscated for the benefit of others. It is not easy to see how such a shifting, to a private group, of financial responsibility for the alleviation of a public problem they did not create could square with the Fifth Amendment's prohibition against taking property without just compensation.

> It is axiomatic that the Fifth Amendment's just compensation provision is 'designed to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole.'

First English Evangelical Lutheran Church v. County of Los Angeles, 482 U.S. 304, 318-19 (1987) (quoting *Armstrong v. United States*, 364 U.S. 40, 49 (1960)).

However, the most closely applicable judicial precedents are to the contrary. For example, in *Whitney*, the Court of Appeals for the Eleventh Circuit ruled that DEFRA's temporary freezing

of the fees charged by physicians to Medicare patients was not a Fifth Amendment "taking" because physicians could refuse to accept such patients:

> It is well established that government price regulation does not constitute a taking where the regulated group is not required to participate in the regulated industry. *Bowles v. Willingham*, 321 U.S. 503, 517-18.... In the instant case, appellants are not required to treat Medicare patients and the temporary freeze is therefore not a taking within the meaning of the Fifth Amendment.

780 F.2d at 972.

Plaintiffs attempt to distinguish *Whitney* on the ground that, as hospital-based anesthesiologists, they may not refuse to treat Medicare patients. But this is, at most, a difference in degree. While it is undoubtedly true that by far the largest share of anesthesiology is performed in hospitals, and hospitals are required by law to accept Medicare patients, plaintiffs have the option of practicing outside of hospitals,[3] and may even be able to practice in hospitals and still decline to serve Medicare patients.[4] There is, of course, a strong economic incentive for them

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[3] Plaintiffs appear to concede this in their assertion that the "vast majority" of anesthesiologists must be hospital-based. *See* Pltf. Reply Mem. at 4. By implication, this statement indicates there must be a minority of anesthesiologists who are not hospital-based.

[4] Defendants contend that New York law merely requires *hospitals* to afford each patient the right to treatment without discrimination as to the source of payment. *Patients' Bill of Rights*, 10 NYCRR § 405.7(c)(2); *see also id.*, § 405.7(b)(2). Defendants aver further that nothing in the law "locks in" any hospital-based anesthesiologist or any other hospital-based physician to treat Medicare patients. As long as a hospital can supply an anesthesiologist who will treat Medicare patients, defendants maintain that a patient's rights are not violated under New York law.

Plaintiffs respond that if a hospital is legally barred from discriminating against patients based on source of payment, it cannot enter into an agreement

(Footnote continued)

to accept Medicare patients, even at the ceiling fees, but the physicians in *Whitney* were under similar economic pressure not to refuse Medicare enrollees, who assertedly constituted 50 to 60% of their patients. 780 F.2d at 967-68.

The *Whitney* court relied upon the decision of the Court of Appeals for the Eighth Circuit in *Minnesota Ass'n of Health Care Facilities, Inc. v. Minnesota Dep't of Pub. Welfare*, 742 F.2d 442 (8th Cir. 1984), *cert. denied*, 469 U.S. 1215 (1985). In that case, the Court upheld Minnesota's restrictions on rates nursing homes which participated in the State's Medicaid program could charge to non-Medicaid residents, ruling that "nursing homes, unlike public facilities, have freedom to decide whether to remain in business and thus subject themselves voluntarily to the limits imposed by Minnesota on the return they obtain from investment of their assets in nursing home operations." *Id.* at 446. The courts in both *Whitney* and *Minnesota Association* relied in turn on the early rent control case of *Bowles v. Willingham*, 321 U.S. 503, 517-18 (1944), in which the Supreme Court held that the rent control provisions at issue did not constitute a prohibited taking because the statute did not require landlords to offer their apartments for rent.

In the instant case, the economic pressure on plaintiffs to continue serving Medicare patients is not clearly greater than the pressures faced by the nursing home operators in *Whitney*, whose only practical alternatives to doing business under price controls were to refuse all medicare patients or to go out of business, or by the landlord in *Willingham*, whose only practical alternative to doing business under price controls was to sell her properties at prices depressed by the rent ceilings. This Court therefore finds these judicial precedents, if not philosophically persuasive, at least legally compelling.

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with individual members of the hospital staff not to treat patients based on source of payment.

Neither side has cited any case law in support of it position, and the Court does not decide the question of whether New York hospitals may reach agreements with hospital-based physicians not to treat medicare patients.

Moreover, it must be noted that even if the facts of this case were such that plaintiff anesthesiologists had no choice but to subject themselves to the Medicare limits imposed by Congress, this would not end the Court's inquiry. Plaintiffs assert that it is "beyond question" that price regulation can amount to a taking,[5] citing, *inter alia*, the public utility rate cases of *Duquesne Light Co. v. Barasch*, 488 U.S. 299 (1989), and *Jersey Central Power & Light Co. v. FERC*, 810 F.2d 1168 (D.C. Cir. 1987). But these cases, and the Supreme Court's seminal decision in *FPC v. Hope Natural Gas Co.*, 320 U.S. 591 (1944), make clear that plaintiffs' burden is not met by showing mere legal compulsion. To the extent that *Hope* and its progeny are applicable in the present context, these cases would require plaintiffs to make a showing that the ceiling at 125% (decreasing to 115% after

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[5] Plaintiffs also proffer a related argument, derived from Justice Scalia's concurring opinion in *Pennell v. City of San Jose*, 485 U.S. 1 (1988). Plaintiffs insist that owners of property subject to government price regulation are singled out unfairly to shoulder public burdens unless their use of the property can be said to be the source of the social evil to be remedied. *See id.* at 20.

Plaintiffs' reliance on Justice Scalia's concurring opinion in *Pennell* is, however, misplaced. The majority of the Court, in an opinion by Chief Justice Rehnquist, upheld the city rent control ordinance at issue, ruling that the law did not violate due process and that petitioner's takings claim was premature. *See id.* at 9-10. Therefore, Justice Scalia's analysis of the takings claim, although it has considerable logical force and may foreshadow a future shift in Supreme Court jurisprudence, is not a binding statement of the law. Furthermore, Justice Scalia's opinion is at odds with settled Supreme Court doctrine that has "consistently affirmed that States have broad power to regulate housing conditions in general and the landlord-tenant relationship in particular without paying compensation for all economic injuries that such regulation entails." *Loretto v. Teleprompter Manhattan CATV Corp.*, 458 U.S. 419, 440 (1982) (citing *Bowles v. Willingham*, 321 U.S. 503, 517-18 (1944)). *See also Penn Central Transp. Co. v. New York City*, 438 U.S. 104, 131 (1978) ("Stated baldly, appellants' position appears to be that the only means of ensuring that selected owners are not singled out to endure financial hardship for no reason is to hold that any restriction imposed on individual landmarks pursuant to the New York City scheme is a 'taking' requiring the payment of 'just compensation.' Agreement with this argument would, of course, invalidate not just New York City's law, but all comparable landmark legislation in the Nation. We find no merit in it.").

1992) of the Medicare fee is insufficient to afford plaintiffs reasonable compensation for their services. *See Hope*, 320 U.S. at 603. Here plaintiffs have not attempted nor even offered to establish that this level of remuneration does not adequately compensate hospital-based physicians for their services.

CONCLUSION

For the above stated reasons, plaintiff patients have no standing in the action. Plaintiff physicians' motion for summary judgment is denied and defendants' cross-motion for summary judgment dismissing all of plaintiffs' claims is granted.

SO ORDERED.

/s/William C. Conner
United States District Judge

Dated: February 14, 1992
New York, New York

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

BERTHA GARELICK, YOLANDA RESTAINO, ELENA SAVINO, DAVID ATKINSON, BRUCE KONRAD and PETER T. PICKERING,

Plaintiffs,

— against —

LOUIS W. SULLIVAN, as Secretary of the Department of Health and Human Services, and WILLIAM TOBY, as Administrator, Health Care Financing Administration, Region II,

Defendants.

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91 Civ. 4524 (WCC)

OPINION AND ORDER

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CONNER, D.J.:

Plaintiffs move for reargument and reconsideration of this Court's Opinion and Order of February 14, 1992 dismissing the anesthesiologist plaintiffs' claim that the federal Medicare scheme limiting the amount which they may charge for their anesthesiology services to Medicare patients constitutes a taking of their property without just compensation in violation of the Fifth Amendment. Plaintiffs contend: (1) that the decision was based upon a "fundamental mistake of fact" in that the Court erroneously assumed that anesthesiologists could avoid serving Medicare patients by practicing outside of hospitals and possibly even by practicing in hospitals but declining to serve Medicare beneficiaries; and (2) that the Court overlooked controlling law on the isue of "just compensation." The motion is granted to the extent that the decision has been reconsidered but is reaffirmed.

In the challenged Opinion, the Court expressly recognized that the medical expertise of anesthesiologists, acquired at considerable expense of time and money, is their only stock in trade, and that if they were compelled to make that expertise available to designated beneficiaries at below-market prices the value of this principal asset would be diminished. However, the Court was constrained to follow the consistent rulings of the most closely applicable prior cases and to hold that this did not constitute a "taking" within the contemplation of the Fifth Amendment.

The Court made the incidental observation that anesthesiologists could avoid any ceiling on their fees by serving only non-Medicare patients, for example by practicing outside of hospitals or by obtaining permission from their hospitals to decline to serve Medicare beneficiaries. In support of their motion for reconsideration, plaintiffs have submitted the affidavits of two anesthesiologists denying that these options are available because (1) the Guidelines for Patient Care in Anesthesiology adopted by the American Society of Anesthesiologists state that "The same quality of anesthetic care should be available for all patients" at all times; (2) the Guidelines for Ambulatory Surgical Facilities

state that the same standards are "applicable to outpatient care;" and (3) the guidelines for Organization of an Anesthesia Department provide that "an anesthesiologist with full staff privileges must share on a fair and equitable basis in the responsibility for assuring 24-hour a day, 7-day a week availability of anesthesia."

The requirement that the "same quality of anesthetic care" be provided to out-patients does not prevent the furnishing of anesthesiological services outside of hospitals; indeed, it clearly contemplates the same. Thus the Court's statement that anesthesiologists could avoid serving Medicare beneficiaries by practicing only outside of hospitals was clearly correct. However, it appears that the Court's speculation that anesthesiologists on hospital staffs might be able to obtain the permission of their hospitals to serve only non-Medicare patients may have been incorrect. Nevertheless this does not change the Court's conclusion that the limitation on charges to Medicare patients does not constitute a Fifth Amendment "taking."

Although, as the Court further recognized, most anesthesiology is performed in hospitals, which are required by law to accept Medicare patients, so that anesthesiologists on hospital staffs apparently cannot escape treating Medicare patients at controlled, presumably below-market, prices, anesthesiologists still have the options of (1) practicing only outside of hospitals and declining to serve all Medicare beneficiaries, or (2) practicing in hospitals, in which event they may serve both Medicare and non-Medicare patients and charge the latter whatever the traffic will bear.

As the Court stated in its Opinion, the diminution of the asset value of the anesthesiologist plaintiffs is similar to that suffered by the physician plaintiffs in *Whitney v. Heckler*, 780 F.2d 963 (11th Cir. 1986), and by the nursing home operators in *Minnesota Assn. of Health Care Facilities v. Minnesota Dept. of Public Welfare*, 742 F.2d 442 (8th Cir. 1984), which in each case was ruled not to constitute a Fifth Amendment "taking."

There is no reason to believe that the percentage of Medicare beneficiaries among the patients treated by the plaintiff

anesthesiologists here, and therefore subject to the fee ceilings, is any greater than among those treated by the physicians in *Whitney*. Moreover, because nursing homes have a high percentage of elderly residents, there is reason to expect that the percentage of Medicare beneficiaries among the residents of the nursing homes operated by the plaintiffs in *Minnesota Association* was even greater. If the Circuit Courts in *Whitney* and *Minnesota Association* found no "taking" because the plaintiffs could decline to serve Medicare beneficiaries, this Court is impelled to the same conclusion.

In view of this ruling, it is unnecessary for the Court to consider plaintiffs' other contention that the Court overlooked controlling law on the issue of "just compensation." If there was no "taking," there is no entitlement to "just compensation."

The Court therefore reaffirms its Opinion and Order of February 14, 1992.

SO ORDERED.

/s/William C. Conner
Senior United States District Judge

Dated: New York, New York
March 24, 1992

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

BERTHA GARELICK, et al.,	:	
Plaintiffs,	:	
— against —	:	91 Civ. 4524 (WCC)
LOUIS W. SULLIVAN, as Secretary of the Department of Health and Human Services, et al.,	:	**AMENDED OPINION AND ORDER**
Defendants.	:	

CONNER, D. J.:

The Opinion and Order, dated February 14, 1992, is hereby amended nunc pro tunc as follows:

Page 6 - First sentence of the second paragraph - The word "judgement" should read — judgment —

Page 6 - Last line - The name "Bertha Garelik" should read — Bertha Garelick —

SO ORDERED.

/s/William C. Conner
Senior United States District Judge

Dated: New York, New York
April 24, 1992

(2)

FILED
AUG 16 1993
OFFICE OF THE CLERK

No. 92-1931

In the Supreme Court of the United States

OCTOBER TERM, 1993

BERTHA GARELICK, ET AL., PETITIONERS

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Whether 42 U.S.C. 1395w-4(g), which limits the fees physicians may charge Medicare beneficiaries, results in a taking of private property without just compensation, in violation of the Fifth Amendment.

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In the Supreme Court of the United States

OCTOBER TERM, 1993

No. 92-1391

BERTHA GARELICK, ET AL., PETITIONERS

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A1-A15) is reported at 987 F.2d 913. The district court's opinion and order of February 14, 1992 (Pet. App. B1-B13), as amended by its order of April 24, 1992 (Pet. App. D1), is reported at 784 F. Supp. 108. The district court's opinion and order of March 24, 1992 (Pet. App. C1-C4) is not yet reported.

JURISDICTION

The judgment of the court of appeals was entered on March 5, 1993. The petition for a writ of certiorari was filed on June 3, 1993. This Court's jurisdiction is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Congress established the Medicare program in 1965 to provide health care for the aged and disabled. See 42 U.S.C. 1395 *et seq.* Under Part B of the Medicare program, eligible individuals may purchase insurance that generally pays 80% of a "federally determined amount" for covered medical services. 42 U.S.C. 1395*l* (Supp. III 1991). The federally determined amount reflects the value of the services, adjusted to take geographic and other considerations into account. 42 U.S.C. 1395w-4(b)(1) (Supp. III 1991).

Under the Medicare program, "participating physicians" agree in advance not to charge Medicare patients more than the federally determined amount for their services, and they are paid by the Medicare program pursuant to an assignment agreement. Thus, a participating physician receives 80% of the federally determined amount directly from the Medicare program, is permitted to bill the patient for the remaining 20%, and agrees not to seek any further payment.

The Medicare program also pays 80% of the federally determined amount for medical services furnished by a physician who treats a Medicare patient but does not accept assignment of the Medicare claim for that service. In such a case, the Medicare program pays the beneficiary, and the physician must look to the beneficiary for payment. Since 1984, Congress has imposed limitations on the fees physicians who do not accept assignment may charge Medicare beneficiaries. In 1989, Congress enacted the provision challenged here, 42 U.S.C. 1395w-4(g)(2) (Supp. III 1991), which prohibits physicians who do not accept assignments from charging Medicare

beneficiaries more than a set percentage of the federally determined amount for their services. For most services rendered after 1992, Section 1395w-4(g)(2) (Supp. III 1991) precludes physicians who do not accept assignment from charging Medicare beneficiaries more than 115% of the fees allowed participating physicians.

In short, under the Part B program Medicare pays 80% of the federally determined amount for covered services. No physician is required by the Medicare program to care for Medicare patients. But if they do so and obtain direct payment from Medicare by assignment, they may not seek more than the remaining 20% from the patient. Physicians who do not accept assignment may not obtain more than 115% of the federally determined amount.

2. Petitioners are three anesthesiologists who contend that the 115% limit constitutes a taking of property without just compensation, in violation of the Fifth Amendment. Pet. 7. They sought a declaratory judgment to that effect and an injunction barring enforcement of Section 1395w-4(g)(2) (Supp. III 1991) with respect to hospital-based anesthesia services. C.A. App. A21.[1]

The district court, ruling on cross-motions for summary judgment, rejected petitioners' contention that the Act effects an unconstitutional taking without just compensation. The court reasoned, first,

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[1] The complaint also named as plaintiffs three Medicare beneficiaries who raised various other constitutional challenges to the 115% limit. The district court held that the beneficiaries lacked standing (Pet. App. B7), the court of appeals affirmed that ruling (*id.* at A15), and the petition does not challenge that ruling or otherwise raise any claim besides the takings claim.

that the 115% limit does not take petitioners' property because petitioners "may decline to serve Medicare patients." Pet. App. B10. The court further held that, in any event, petitioners had failed to demonstrate that the 115% limit "is insufficient to afford plaintiffs reasonable compensation for their services." *Id.* at B13.

The district court subsequently denied petitioners' motion for reconsideration. It concluded that petitioners are not compelled to serve Medicare beneficiaries notwithstanding various voluntarily adopted professional standards and guidelines pertaining to the quality and availability of anesthetic care. It also concluded that any diminution of the "asset value" of the physicians' medical expertise caused by the 115% limit does not amount to a taking for purposes of the Fifth Amendment. Pet. App. C2-C3.

3. The court of appeals affirmed. Pet. App. A1-A15. Like the district court, the court of appeals first concluded that the statute does not result in a taking because it does not compel physicians to serve Medicare beneficiaries and subject themselves to the 115% limitation. *Id.* at A6-A7. The court of appeals further rejected petitioners' argument that various state regulations, voluntary professional standards governing the quality and availability of care, and the economics of petitioners' professional practice supplied the necessary element of compulsion. First, it held that the state law provisions on which petitioners relied, which require hospitals to refrain from discriminating against patients on the basis of the source of payment (see N.Y. Comp. Codes R. & Regs. tit. 10, § 405.7 (1969)), do not apply to individual physicians, and that in any event state-law

requirements do not determine whether a federal statutory scheme results in a taking of property within the meaning of the Fifth Amendment. Pet. App A9. Second, the court held that voluntary practice standards are self-imposed requirements and therefore do not constitute governmental compulsion to employ property for a public purpose. *Id.* at A10. Third, the court held that economic inducement to participate in the Medicare program does not compel petitioners to serve Medicare beneficiaries and thereby subject themselves to governmental regulation of their professional fees. *Ibid.*

The court also rejected petitioners' contention that the Act results in a taking because it requires selected private individuals to bear the burden of remedying "a social ill that the regulated property owner has neither contributed to nor created." Pet. App. A10. The court reasoned that this approach, although articulated in Justice Scalia's separate opinion in *Pennell* v. *City of San Jose*, 485 U.S. 1 (1988), has not been adopted by a majority of this Court and does not reflect controlling precedent. That controlling precedent preserves the government's "broad power to determine the proper subjects of and purposes for regulatory schemes." Pet. App. A11.

ARGUMENT

The court of appeals correctly held that federal regulation of the fees charged Medicare patients is not a "taking" of property without just compensation. The court of appeals also correctly noted that "[a]ll court decisions * * * that have considered takings challenges by physicians to Medicare price regulations have rejected them in the recognition that

participation in Medicare is voluntary." Pet. App. A8. Further review therefore is not warranted.

1. The Fifth Amendment provides that private property shall not "be taken for public use without just compensation." Petitioners' central contention is that the challenged statutory provision results in a taking because, by limiting their fees to 115% of the federally determined amount, the provision forces them to employ their property to further a public purpose—subsidization of medical services for elderly and disabled Medicare patients—whose burden should be borne by the public as a whole. Pet. 7-8. That argument is incorrect, however, for at least two independent reasons.

a. First, as the court of appeals held, the Medicare Act does not compel petitioners to care for Medicare beneficiaries and thereby subject themselves to the 115% limit. There is no taking of private property by the federal government where no federal statute requires persons to use their property for a public purpose in the first instance. *Bowles* v. *Willingham*, 321 U.S. 503, 517 (1944) (federal rent control regulation did not effect a taking where the federal statute did not require the property to be used for purposes that would subject the owner to price regulation). The courts of appeals have uniformly rejected takings challenges to the Medicare Act on the ground that it does not require physicians to care for Medicare patients. *Whitney* v. *Heckler*, 780 F.2d 963, 972 (11th Cir.) (temporary freeze of Medicare payments is not a taking because physicians are not required to treat Medicare patients), cert. denied, 479 U.S. 813 (1986); *Burditt* v. *United States Dep't of Health & Human Services*, 934 F.2d 1362, 1376 n.12 (5th Cir. 1991)

(Medicare requirement that hospitals provide certain emergency care services does not take physicians' property because individual physicians are not required to provide such care).

Petitioners maintain that a web of state regulation and professional ethical obligations effectively compels them to treat Medicare beneficiaries and thereby subject themselves to the 115% limit. As an initial matter, petitioners' assertion that state law requires them to serve Medicare beneficiaries is incorrect. Petitioners rely on New York State's "Patient Bill of Rights," which provides in pertinent part that a "hospital shall afford to each patient the right to * * * treatment without discrimination as to * * * source of payment." N.Y. Comp. Codes R. & Regs. tit. 10, § 405.7(b)(2) (1969). As the court of appeals noted, that provision applies to hospitals, not individual physicians. Pet. App. A9. It thus plainly has no application to an anesthesiologist who provides out-patient services, and does not necessarily apply to all anesthesiologists who provide in-patient services. In any event, none of petitioners' contentions, even if correct, would demonstrate that it is the federal statute challenged here that caused any taking of petitioner's property, and we are not aware of any case holding that requirements imposed by a state government or private organization can render an otherwise valid federal legislative enactment constitutionally infirm.[2]

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[2] Moreover, the basis for petitioners' claim—that the Medicare statute has taken their property by limiting the return on their investment in education and training—is novel. We are aware of no case upholding a takings claim based on such a theory. See *Burditt*, 934 F.2d at 1376 & n.12. The Court

b. Even if we assume, for purposes of argument, that the Medicare Act compels petitioners to employ their property for a public purpose, the relevant inquiry requires consideration of (1) the character of the governmental action, (2) the severity of the economic impact on the claimant, and (3) whether the statute interferes with reasonable investment-backed expectations. See, *e.g.*, *Concrete Pipe & Products of California, Inc.* v. *Construction Laborers Pension Trust For Southern California*, 113 S. Ct. 2264, 2290-2291 (1993). The 115% limit does not amount to a taking under that test.

First, governmental regulation of prices charged for important goods and services is an exercise of the government's police power to further the general public good, rather than to invade or convert property for a public purpose. Any interference with private economic interests "arises from a public program that adjusts the benefits and burdens of economic life

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has never suggested that the Constitution requires a particular return on investment in education and professional training. The Court has extended the protections of the Just Compensation Clause to intangible assets only where some independent source of law gives rise to a reasonable expectation that the asset in question will be safeguarded from interference or economic impairment. Cf. *Ruckelshaus* v. *Monsanto Co.*, 467 U.S. 986, 1001-1004 (1984); *Penn Central Transp. Co.* v. *New York City*, 438 U.S. 104, 124-125 (1978). Petitioners have not identified any settled rule, understanding, or source of law that would afford them a constitutionally protected property interest in some particular rate of return on whatever resources they have invested in their professional education and training. Thus, although the court of appeals did not reach the issue, its judgment would stand on the alternative ground that Medicare regulation of professional fees does not take private property within the meaning of the Just Compensation Clause.

to promote the common good and, under [the Court's] cases, does not constitute a taking requiring Government compensation." *Connolly* v. *Pension Benefit Guaranty Corp.*, 475 U.S. 211, 225 (1986).

Second, the Medicare Act does not have a severe impact on physicians' fees. As an initial matter, it should be kept in mind that, by providing a source of payment for 80% of the federally determined amount, the Act has a favorable economic effect on physicians. Moreover, the limit challenged here merely prevents physicians from collecting more than 115% of the federally determined amount. As this Court stated in *Concrete Pipe*, 113 S. Ct. at 2291, it is "long established that mere diminution in the value of property, however serious, is insufficient to demonstrate a taking. See, *e.g.*, *Euclid* v. *Amber Realty Co.*, 272 U.S. 365, 384 (1926) (approximately 75% diminution in value); *Hadacheck* v. *Sebastian*, 239 U.S. 394, 405 (1915) (92.5% diminution)." In light of those holdings, it is clear that petitioners—who have "not attempted nor even offered to establish that this level of remuneration does not adequately compensate hospital-based physicians for their services," Pet. App. B13—have no viable claim that the 115% limit has taken their property.

Third, the Act does not unduly interfere with any of petitioners' reasonable, investment-backed expectations. Health care is a pervasively regulated field, and Congress has specifically imposed restrictions on the fees physicians may charge Medicare beneficiaries since 1984. See Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, Tit. III, § 2306, 98 Stat. 1070, codified at 42 U.S.C. 1395u(j)(1)(A). In light of this history of regulation,

petitioners, who allege that they have provided in-hospital anesthesia services since January 1, 1991, C.A. App. A47, have no reasonable expectation that they will have unfettered authority to charge Medicare patients any fee they deem appropriate.

2. Petitioners base their argument that review is warranted primarily (Pet. 8-11) on Justice Scalia's separate opinion in *Pennell* v. *City of San Jose*, 485 U.S. 1 (1988). In his separate opinion, Justice Scalia argued that a rent control statute constituted a taking insofar as it required consideration of hardship to the tenant in calculating the rent, because the statute required landlords to assume the cost of remedying a social problem they had not caused: the inability of some tenants to pay their rent. *Id.* at 20-22. As an initial matter, the approach advocated in that separate opinion has not been adopted by the Court, which has continued to weigh the character of the governmental action, the severity of the economic impact on the claimant, and whether the statute interferes with reasonable investment-backed expectations. See, *e.g.*, *Concrete Pipe & Products of California, Inc.*, 113 S. Ct. at 2290-2291.

Moreover, this is not a case in which the approach advocated in the separate opinion in *Pennell* should lead to a different result. The rent control statute at issue in *Pennell* had no provision under which the City of San Jose paid a portion of the rent owed by poor residents. Medicare, in contrast, provides funds for payment of 80% of the federally determined amount. In addition, the rent control statute at issue in *Pennell* envisioned reduction of the allowable rent below an amount determined to be reasonable if the tenant could not afford to pay the reasonable rent. 485

U.S. at 21. Medicare, in contrast, allows physicians to charge 115% of the federally determined amount. Because Medicare provides funds to pay a large portion of physicians' fees—and because the challenged statutory provision allows physicians to collect 15% more than their colleagues who accept assignment of Medicare claims—no reasonable test could lead to the conclusion that petitioners' property has been taken.

For much the same reason, petitioners' invocation (Pet. 11-12) of *Lucas* v. *South Carolina Coastal Council*, 112 S. Ct. 2886 (1992), is inapposite. The Court in that case was faced with a situation in which "the owner of real property has been called upon to sacrifice *all* economically beneficial uses in the name of the common good." *Id.* at 2895. Petitioners have not been compelled to treat patients for free. Instead, they merely are forbidden to charge more than 115% of an amount that other physicians find acceptable when they choose to treat Medicare patients.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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No. 92-1931

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

BERTHA GARELICK, *et al.*,

Petitioners,

VS.

DONNA E. SHALALA, Secretary of the U.S. Department of Health and Human Services, and WILLIAM TOBY, Administrator, Health Care Financing Administration,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

PETITIONERS' REPLY BRIEF

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PETITIONERS' REPLY BRIEF

A. *Respondents' Concessions*

Respondents' brief (Resp. Br.) makes several important concessions:

1. The 1989 Medicare fee cap statute is an exercise of the police power for the *public good* (Resp. Br. p. 8) putting this case squarely in the posture of anesthesiologists being forced to pay to ameliorate a social problem which they did not create. The rationale of Justice Scalia's separate opinion in *Pennell v. San Jose*, 485 U.S. 1, 15 (1988) therefore would apply if accepted by other members of the Court.

2. The source of the compulsion to treat all Medicare cases originates under state law and professional ethics and therefore presents a *novel* question of constitutional law. (Resp. Br. p. 7.)

3. Each of these concessions demonstrates why the Court should grant certiorari in this case. On top of these is the Court's recent decision in *Concrete Pipe & Products of California, Inc. v. Construction Laborers Pension Trust For Southern California*, 113 S.Ct. 2264 (1993) which respondents apparently believe overruled the long-standing takings clause rule in public utility cases. The applicability of the holding in *Concrete Pipe* to regulation of rates chargeable for compulsory services therefore demands further refinement and clarification and this is the case in which to do it.

B. *Respondents' Factual Oversights*

The arguments in respondents' brief are primarily theoretical and written in the abstract – far removed from the factual realities of this case. They overlook or misconstrue the following facts, which when properly understood compel a different conclusion:

1. This case relates solely to anesthesiologists, who are key members of every major surgical team. Anesthesiologists do not function independently but as part of the life-support system in hospital operating rooms. In many cases, the success of a surgical procedure (e.g., open heart surgery) depends on the anesthesiologist's monitoring of vital signs and availability to respond immediately to emergencies as they arise on the operating table.

2. Anesthesiologists have no choice in the patients they treat. They may not refuse to care for a patient because he or she is on Medicare. This was the existing situation *before* the Medicare statute was first enacted in 1965 and was the situation when the challenged fee cap was enacted in 1989. This is not the case of *subsequent* state government action[1] or professional

[1] The New York State "Patients Bill of Rights" adopted in 1977 was intended merely to codify existing standards.

requirement.[2] It has always been the case. Congress enacted the Medicare balanced billing fee cap in the face of an existing compulsion, which was part of the factual context for the statute, and necessarily incorporated in the statute's premise. It cannot be separated out in isolation as the Court of Appeals and respondents have done.

3. The New York State statute requiring hospitals to treat all patients alike regardless of source of payment does not exist in a vacuum. It cannot be implemented by the hospital alone. The medical staff is part of the hospital, and the attending anesthesiologists are subject to the hospital's control and discipline. If a staff doctor refuses to comply with the hospital's legal obligations he or she is subject to loss of hospital staff privileges.

4. The Medicare fee cap at issue here is *not* the amount to be paid by the Federal Government, but is the amount to be paid by the patient, without regard to income or available resources. It applies equally to millionaires and to paupers.

5. The loss of income to anesthesiologists is substantial. The usual and customary market rates charged by petitioners in this case to non-Medicare patients was $70 per 15-minute unit, compared to $19.99 for Medicare beneficiaries, *including* the 115% fee cap. (*See* record in courts below.)

6. New physicians choosing the field of anesthesiology must invest tens of thousands of dollars in their education — the median cost for four years medical training for all doctors is expected to be $79,160 for the class of 1995. New physicians emerge from medical school with an average student loan indebtedness of $50,000. (*Newsweek*, April 5, 1993, p. 31.)

7. Anesthesiologists do not "collect 15% more than their colleagues who accept assignment of Medicare claims" (Resp. Br. p. 11). The "colleagues" of anesthesiologists are other anesthesiologists, who rarely accept assignment, and surgeons

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[2] The anesthesiologists' ethical obligation to treat all patients equally was first codified in 1985, but again reflected existing standards.

(who are free to refuse Medicare cases). Most of the physicians who accept assignment in Medicare cases are internists, family doctors and other office practitioners who are able to streamline their office procedures to realize a reasonable income from a large number of small Medicare payments, sometimes supplemented by laboratory tests and other income-generating extras. These are not the true "colleagues" of operating room anesthesiologists, who do not see office patients but instead are assigned to operating rooms where they *must* treat every patient who comes along – including cases which come up when they are on 24-hour emergency call.

C. *Question Presented*

The question presented on this appeal is not as stated in Respondents' Brief (p. I):

> Whether 42 U.S.C. 1395w-4(g), which limits the fees physicians may charge Medicare beneficiaries, results in a taking of private property without just compensation, in violation of the Fifth Amendment.

Rather it is whether the statute results in an unconstitutional taking *when applied to anesthesiologists*, who may not refuse to treat Medicare beneficiaries.

Petitioners recognize the prior holdings that Medicare fee limits are constitutional for doctors who are free to refuse to treat Medicare beneficiaries. But what of those who are not?

This is not a grab for more money – it is a plea for fairness. Most anesthesiologists are perfectly willing to lower their fees for patients of limited means, but why should they be required to take a cut for millionaire patients who happen to be enrolled in Medicare? This is not a question of Medicare paying for the service (as in "assigned" cases), but rather of the patient paying the difference between the Medicare allowance and the fair market value. Why should Congress mulct the doctor to help the rich?

When a federal statute requires a doctor *who has no choice* to accept a deep cut in his fee from a wealthy patient, there is a constitutional obligation to correct the inequity.

The Constitution is *not* money-blind.

ARGUMENT

Respondents incorrectly cite *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986 (1984), in support of their suggestion that petitioners have no property interest in receiving "a particular rate of return on whatever resources they have invested in their professional education and training." (Resp. Br. 8.)

Petitioners assert a property interest in their performance of medical services. It cannot be disputed that anesthesiologists and other licensed physicians have a right under state law to render such services and collect fees. Petitioners' services thus fully meet the definition of protected property interest set down in *Ruckelshaus*. (467 U.S. at 1001.) What petitioners seek as compensation for this property is the market rate, in accordance with settled takings clause jurisprudence. (*See U.S. v. Fifty Acres of Land*, 469 U.S. 24, 25-26 (1984).)

The significance of petitioners' investment in education and training, in contrast to the nursing home owners in *Minnesota Association of Health Care Facilities v. Minnesota Department of Public Welfare*, 742 F.2d 442 (8th Cir. 1984), *cert. denied*, 469 U.S. 1215 (1985), is that petitioners' investment will be *totally* destroyed if they withdraw from practice. (Pet. 12-13, n. 6.)

Respondents rely heavily on the decision in *Connolly v. Pension Benefit Guarantee Corp.*, 475 U.S. 211, 225 (1986) to support their argument that the Medicare fee caps do not effect a taking of petitioners' property. (Resp. Br. 8-9.) *Connolly*, however, does not stand for the proposition that Congress may interfere with private economic interests in any manner it deems fit, in order to "adjust the benefits and burdens of public life." *Cf.*, *Connolly*, 475 U.S. at 229 (". . . the Court has never intimated that Congress possesses unlimited power to readjust rights and burdens and upset otherwise settled expectations." (O'Connor, J.,

concurring and quoting *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 16 (1976).)[3]

Connolly, in fact, specifically endorsed the principle relied on by petitioners here, that the "purpose of forbidding uncompensated takings of private property for public use is 'to bar Government from forcing some people alone to bear public burdens which, in fairness and justice should be borne by the public as a whole.' " *Id.* at 227, *quoting Armstrong v. United States*, 364 U.S. 40, 49 (1960).

Specifically, this Court in *Connolly* determined that it was neither unjust nor unfair to require employers withdrawing from multi-employer pension plans to pay over to the plans the employer's proportionate share of "unfunded vested benefits." 475 U.S. at 227. The Court suggested that employers generally were the source of the social evil to be remedied by virtue of their practice of "unregulated withdrawals from multiemployer plans [which] could endanger [the plans'] financial vitality and deprive workers of the vested rights they were entitled to anticipate would be theirs upon retirement." *Id.* at 227.

Moreover, the Court found the employers in that litigation voluntarily negotiated and maintained a pension plan which was later determined to be within the strictures of ERISA. *Id.*

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[3] Respondents assert that the fee caps do not "unduly interfere with any of petitioners' reasonable, investment-backed expectations" since "health care is a pervasively regulated field," and Congress has regulated physician fees to Medicare patients since 1984. Resp. Br. p. 9. However, the petitioners had no reason to expect the *permanent* compulsory cap on their fees imposed by the present act, since the two prior fee limitations were both, by their terms, temporary restrictions. (*See* Pet. App. A-4; 42 U.S.C. § 1395u(j) (1)(B).) Furthermore, respondents' contention has no applicability in the instant case, which as noted below, is governed by cases dealing with public utilities. *See, e.g. Colorado Springs Credit Association v. Farm Credit Administration*, 967 F.2d 648, 656, n. 8 (D.C. Cir. 1992) ("In this era of pervasive regulation, this factor might prove far too much: almost any entity could be said to have a reasonable expectation of governmental intrusion. If the existence of regulation were critical to takings claims, the long-established principle that a public utility has had its property taken if its rates are set too low would appear rather dubious. *See, e.g., Duquesne Light Co. v. Barasch*, 488 U.S. 299, 307-08, 109 S.CT. 609, 615, 102 L.Ed.2d 646 (1989).")

Thus, there is a sharp distinction between *Connolly* and this case, in which petitioners 1) *must* treat Medicare patients and do not voluntarily subject themselves to the fee caps, and 2) are not the cause of the inability of some Medicare patients to pay fair market rates for medical services.

Since the petitioners are not the source of the social evil to be remedied, the fee caps amount to a taking, under the logic of Justice Scalia's separate opinion in *Pennell*. 485 U.S. at 20.

The Court of Appeals for the Second Circuit recognized that the Scalia opinion in *Pennell* was "appealing," but found that "[u]ntil Justice Scalia's view is adopted by a majority of the Court, this taking theory must fail." (Pet. App. A-11.) This case warrants review as a vehicle to test whether the view of Justice Scalia in *Pennell* will prevail in the case of physicians who are compelled to render their services at government dictated prices. *See also* the District Court's Opinion to the effect that:

> Justice Scalia's analysis of the takings claim . . . has considerable logical force and may foreshadow a future shift in Supreme Court jurisprudence. . . .
>
> (Pet. App. B-12.)

Similarly, the decision in *Concrete Pipe & Products of California, Inc. v. Construction Laborers Pension Trust For Southern California*, 113 S.Ct. 2264 (1993), cited by respondents for the principle that a diminution in value cannot equal a taking, is not controlling in this case. First, *Concrete Pipe* dealt with the same statutory scheme as that at issue in the *Connolly* case and is thus inapplicable here, where the anesthesiologists are not the source of the social evil to be remedied.

Moreover, *Concrete Pipe* dealt with a one-time taking in the form of 46% of shareholder equity of plaintiff employer. *See* 113 S.Ct. at 2291. The instant case, in contrast, deals with *permanent* price regulation imposed on a *compulsory service*. Therefore, the decisions governing this case are those pertaining to regulation of public utility rates. *See, e.g., Duquesne v. Barasch*, 488 U.S. 299 (1989). (*See* Pet. p. 13.) Respondents fail even to address this crucial distinction.

The utility cases hold that failure to pay reasonable compensation for mandated utility services is a taking of property without just compensation in violation of the Fifth Amendment: *See Duquesne*, 488 U.S. at 307-308; *see also Minnesota Association of Health Care Facilities, Inc.*, 742 F.2d at 446.

At one time, utility cases employed a "fair value rule" which was based on the value of the utility's assets and sought to "mimic the operation of the competitive market." *Duquesne*, 488 U.S. at 308. Later decisions varied from this method because:

> the exchange value of a utility's assets, such as powerplants, could not be set by a market price because such assets were rarely bought and sold. Nor could the capital assets be valued by the stream of income they produced because setting that stream of income was the very object of the rate proceeding. (*Id.* at 309.)

In the instant case, however, the market value of the taken service is readily ascertainable — i.e. the physicians' actual charge to private patients — and there is no reason to depart from the standard fair market measure of reasonable compensation.

The fee caps which limit petitioners to 28% of market value (see *supra* Par. B(5)) are therefore unreasonable and confiscatory and constitute a taking in violation of the Fifth Amendment.

Finally, to the extent that *Concrete Pipe* conflicts with the long standing utility cases, certiorari should be granted to clarify the state of the law in this regard.

CONCLUSION

Accordingly, we pray that the petition for certiorari be granted.

Dated: New York, New York
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